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ABSTRACT

Rural residents have traditionally received fewer essential health care services than their urban counterparts because of lack of coherent health care policy, institutional and regulatory impediments, and the special costs of delivering health care in a rural setting. Lack of adequate health services affects all rural residents, including children. With this in mind, health care providers, insurance representatives, state legislators, health care associations, and State Health Department and Social Services Department staffs convened a symposium in order to identify the key issues and outline a framework for improving health care policy and services for rural New Yorkers. This report contains highlights of four separate workshop discussions with the specific recommendations made by each group. All four workshop groups independently arrived at similar conclusions and recommendations about state policy, regulations and codes, communication and representation, joint ventures, research, finance, and personnel. Workshops recommended stimulating recruitment and retention of health care workers, providing more administrative backup, improving financial support, and providing dollar incentives in terms of taxes, insurance, and education. The report also describes the conerence setting history, and opening session, and contains a list of conference participants, resource contacts, and abstracts of the white papers prepared for the symposium. (DHP)

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A Rural Resources
Special Focus Report

Toward A Rural Health Policy In New York State

Legislative Symposium Proceedings
November 14-15, 1985
Bassett Hall Conference Center
Mary Imogene Bassett Hospital
Cooperstown, New York

New York State Legislative Commission on Rural Resources
April 1986

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The Legislative Commission on Rural Resources wishes to thank all of the conference attendees and rural health care participants and patients, who so kindly consented to use of their photos in this report.

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Cover Photo
The Mary Imogene Bassett Hospital in Cooperstown, N.Y.

To the Readers of this Special Focus Report:

For the past three years, the Legislative Commission on Rural Resources has made a considerable effort to assist state and local policymakers in discussing issues of critical importance to rural New Yorkers. The development of a rural health policy is one such issue.

The Rural Health Symposium held in the Fall of 1985, which is the subject of this report, probably wouldn't have been possible to organize five years ago. But now, people are starting to take notice and listen to the needs of rural New Yorkers.

One of the Commission's foremost publications was aptly titled "Rural New York in Transition," and perhaps one of the best examples of this transition can be seen in the area of health care. New reimbursement policies, alternative care providers, new regulations and codes, and public demand for the control of health care costs and the enhancement of services in general, are all affecting the delivery of health services in rural areas (and urban areas as well).

Therefore, the work of those attending and participating in the Rural Health Symposiur in Cooperstown is of vital importance today. Their recommendations to improve health care policy for rural New York come from years of experience in living in rural areas and in working in all aspects of rural health care. Participants certainly were in agreement on many issues and strategies since all four symposium groups, working independently, made some strikingly similar recommendations.

Work accomplished at Cooperstown has already surfaced within the legislative process in the form of a co-sponsored bill introduced March 1986 in both houses. This bill would authorize the commissioner of health to "establish pilot projects in rural areas...for the purpose of creating cooperative service programs and networks among rural health care providers." It would further authorize the commissioner to approve pilot project grant awards from $10,000 to $50,000 annually for as many as three years.

As we follow the progress of this bill in the legislature, I fully expect this report to be the impetus for creating other related proposals, some of which will perhaps not require legislative action, but rather a coordination of efforts and ideas. Besides serving as a resource document for the individuals and groups represented at the symposium, this report will be turned over to Senate and Assembly committees and to the heads of all involved state agencies, notably the Departments of Health, Social Services, and Education. It will also be sent to federal and local officials.

Our Commission, by expanding this debate, stands in the position of being a moderator as well as an advocate. Our primary interest is in seeing the debate channeled into actions that will enhance the rural health care system in this state. To this end, we will continue to help coordinate the flow of information and the exchange of ideas on these issues.

Charles D. Cook, Senator
Chairman
Legislative Commission on
Rural Resources

April 1986

Conference Setting — Cooperstown, N.Y.

Rural N.Y. State... the Conference Setting

Photo Credit: Mark Zeek

"...there are signs of poverty amid some of the most beautiful countryside in America..."

As people traveled to the rural health symposium with social, technological, and legislative changes in their minds, familiar autumn changes were in the air. Branches on the hardwood trees were bare, and there were hints of winter in the November clouds.

Coming by highway to Cooperstown means traveling through parts of rural New York State. The drive takes one through long stretches of isolated farmland with no sign of the building booms seen in other areas of the state. In fact there are signs of poverty amid some of the most beautiful countryside in America: rolling hills and fertile valleys, scenic woods, rivers, and lakes.

Miles and miles roll by. Here a farmhouse and a working farm; there a cluster of houses in a hamlet. An abandoned farm with its once sturdy barns and stone walls crumbling in painfully obvious decay; then an intersection with a gas station and a mom-and-pop general store, a post office, and a blinking yellow traffic light. You pass a schoolhouse and a volunteer fire department on occasion, but they are few and far between, as are the small towns you pass through, or glimpse in a distant valley.

As participants neared Cooperstown, though, they began to see signs of affluence — new houses under construction, and stone walls straight and firm. An opulently green golf course borders Otsego Lake, with its marina; and well-known museums and resorts are prospering. This was the birthplace of baseball and the home of James Fenimore Cooper, the "Deerslayer."

You are suddenly in an idyllic setting, the crystal lake a sparkling bowl surrounded by protective hills; a jewel among many such settings to be found in rural New York. Yellow and red leaves still ornament the hardwood branches in this sheltered environment. While time has already passed into the next season in outlying areas, autumn is still asserting itself in Cooperstown.

Some conference participants walked through the village to the lower end of the lake where the Susquehanna River and the annual Governor Clinton Canoe Regatta begins, and looked back, to see a scene still vaguely softened by fall colors. A white church steeple on the western hillside overlooks the community of well-kept buildings. Reminiscent of New England, Cooperstown, the seat of county government in Otsego County, is a "pretty how town...up so floating, many bells down," as in the poem by e.e. cummings. It is easy to understand how people coming to work at this conference might be inspired by the natural beauty of the landscapes of rural New York, and by the inviting comfort and charm of villages like this.

In the relative affluence and seclusion of the village, excellent health care services are within easy reach — the Mary Imogene Bassett Hospital, a noted teaching hospital, is a powerful influence. Its healing touch radiates outwards, and patients from nine rural and urban counties are served here, but in the surrounding remote miles, good health care is more difficult to obtain. It is the diversity of this mix — multiplied many times by different demographic and geographic factors around the state, then made infinitely more complicated by personal circumstances — it is this unique variety of human needs, geography, and health care resources that participants at the conference in Cooperstown sought to address.

"...it is this unique variety of human needs, geography, and health care resources that participants at the conference in Cooperstown sought to address."

Special Thanks

"Participation of members from rural health care sectors across the state was far greater than originally foreseen."

Legislative leaders who participated in the rural health care symposium were Senators Charles D. Cook and L.S. Riford, and Assemblymen James Tallon and Anthony Casale. They wish to thank all participants. Participation of members from rural health care sectors across the state was far greater than originally foreseen. The Commission was gratified by this overwhelming response and wishes to recognize the significant contribution of each participant, whose name and affiliation are cited in the appendix to this report.

Special thanks especially go the Mary Imogene Bassett Hospital and its Director, Doctor William F. Streck, who hosted the conference and gave necessary support every step of the way.

The conference planning committee was composed of David L. Boucher, Ronald C. Brach, Jo-Ann Costantino, Leonard M. Cutler, John J. Finn, Seth Gordon, Mickey Hall, Darrell Jeffers, Robert M. Latham, Warren Marcus, Gladys Olmsted, Ronald Rouse and Doris Warrick. They provided the expert advice and energy necessary to put the conference together, make it work effectively for all concerned, and finalize this conference report. A debt of gratitude is owed to the state legislators, state and local agencies and organizations represented by these staff members, for allowing them to help plan and manage the conference.

Four white papers were prepared on topics identified by the planning committee as being the cornerstones for the analysis and development of rural health care policy at this time. These reports were issued to participants in advance of the conference and helped focus and stimulate the discussions that followed. The authors of these papers are recognized for their special contribution to the success of the conference.

Special thanks also go to Eleanor Maio of the Commission staff and to David L. Boucher and Mary Ann Vunk of Bassett Hospital who helped organize and coordinate conference arrangements that functioned smoothly and effortlessly, and to Joe Nash and Julie Austin who helped edit and type this report.

Finally, we wish to acknowledge and thank Doug Allen, who attended the rural health symposium and wrote this report of the conference proceedings. It was through his skill and sensitivity in interacting with the planning committee and conference participants that this report has been put together in a timely and useful fashion for the benefit of those interested in the development of rural health policy in one of the nation's most popular, and rural, states.

Ronald C. Brach
Executive Director
Legislative Commission
on Rural Resources

Executive Summary

"New York's rural residents... have traditionally received fewer essential health care services than their urban counterparts."

New York's rural residents (numbering over three million) have traditionally received fewer essential health care services than their urban counterparts. The reasons are many, but most stem from three factors:

- the lack of a coherent state rural health care policy and blueprint for the development of health care services within rural areas;
- the many institutional and regulatory impediments with which rural health providers must continually struggle; and
- the special costs of delivering health care in a rural setting.

Other critical reasons for fewer services are low population density, the absence or fragmentation of public transportation services, and extremely limited financial or community resources. Add to these conditions the changes taking place in health care in general across the state — new reimbursement policies, federal budget constraints, the addition of alternative service providers, and public pressure to control health costs and increase the quality and range of services — and it can be seen that the burden on rural hospitals and other rural service providers is becoming even greater. Many of the providers located in rural areas are small organizations, and in order for them to continue and expand their services in the current climate of change, regulatory flexibility and innovative approaches are called for, to foster the integration of services within rural areas.

"The objective of the symposium was to identify the key issues and outline a framework for improving health care policy and services for rural New Yorkers."

With this in mind, health care providers, insurance representatives, state legislators, health care associations, and State Health Department and Social Services Department staffs convened at a Rural Health Symposium in Cooperstown, New York on November 13 and 14, 1985. The objective of the symposium was to identify the key issues and outline a framework for improving health care policy and services for rural New Yorkers.

The "Workshop Summaries" section of this report contains detailed highlights of the separate workshop discussions, with the specific recommendations made by each group. While the variety of information reflects differences in their analytic approaches and in the assigned topics, it is most interesting to note that all four workshop groups independently arrived at similar conclusions and recommendations that can be put into six categories: state policy, regulations and codes; communication and representation; joint ventures; research; finance; and personnel. The recommendations, in one way or another, are aimed at developing a positive, decisive statewide policy that treats rural New York residents fairly and properly, and they also can serve as a general framework for improving all areas of rural health care.

What follows here is an outline of the many findings and recommendations held in common by participants. Symposium participants believe that these are the critical health care needs which must be addressed if more equitable access to better quality services is to be provided for individuals and families residing in rural New York today.

State Policy, Regulations, and Codes

A number of state health codes and other regulatory requirements not only place an undue burden on rural health care providers, but they increase the costs of providing care. For example, the state hospital code requires specific minimum staffing levels and restricts the cross utilization of personnel in obstetrical suites. Additionally, requests for proposals (RFPs) frequently are geared toward an urban scale in terms of size of facility and number of clients to be served, thereby reducing the prospect that rural providers will qualify for a particular program.

"...the state must become more sensitive and responsive to unique rural conditions and needs."

All groups agreed that the state must become more sensitive and responsive to unique rural conditions and needs. Specific findings reported by all the workshops can be summarized by the following paragraphs:

- There is a critical need for a comprehensive rural health care policy in New York State that would set guidelines for such areas as finance, reimbursement rates, personnel, regulations, transportation, payment programs, integrated health systems, alternative providers, and emergency medical services. Currently, rural providers must deal with a burdensome and costly monolithic state policy geared to urban institutions.

"...Many of these state-level mandates were promulgated on assumptions based on urban conditions."

- Existing regulations and codes create excessive administrative burdens on rural health care providers. Many of these state-level mandates were promulgated on assumptions based on urban conditions — which makes it difficult for relatively small and isolated rural providers to comply. Now, with even more changes in health care about to occur, the delivery of essential services in rural areas, according to many Symposium participants, will be increasingly more difficult to provide.

The consensus recommendations in this category are to:

- Provide a statewide blueprint for primary care needs in rural areas.
- Encourage and promote new or enhanced services — services that may be provided differently (than in cities) because of the rural situation — such as primary care, illness prevention, extended care, home health care, and respite care.
- Establish an advocacy group or commission to review existing regulations for relevance, and monitor proposed regulations for their impact on rural health care.
- Allow hospitals more flexibility in the use of charity dollars and investment revenues.

Communication and Representation

More and better communications among rural providers themselves and between those providers and the state, was urged by all four groups. Specifically:

- Provide rural health care representation in policy-making forums of state government.
- Establish an information-sharing network among rural health care providers.
- Clarify and deal with existing stumbling blocks in presenting ideas to the Department of Health and the legislature.
- Encourage regulatory coordination among state agencies and between state agencies and external accrediting/licensing bodies.

Joint Ventures

Joint and cooperative ventures are two ways rural providers can both improve services and lower their costs. So, workshop participants recommend there be enhanced local, regional, and statewide networks or multi-institutional working agreements among providers to help:

- Eliminate unnecessary duplication of services.
- Reduce "per unit" costs both in purchasing and delivery of services.
- Meet "critical mass" requirements for such specialized services as obstetrics and emergency room service, where the number of clients served or procedures performed may be relatively small and uneconomical.
- Develop innovative programs of care involving similar types of health care providers or providers who offer different types of services.
- Promote efficiency of operation.

Research

Through the years, research and reporting about rural areas — and about rural health care — have lagged behind similar work for urban areas. Specific recommendations to address this imbalance:

- Canvass New York State and other states for successful models of innovative programs that could be useful in rural New York.
- Collect data to support proposals for increased rates and regulatory changes.
- Maintain a data base which identifies the true costs of providing health care services in a rural setting.
- Periodically inventory and continually monitor existing resources and services; assess rural health care needs of individuals and families; identify service gaps to be filled and ways these could be closed.
- Catalog and continually assess the principal impediments and strengths of health care delivery in rural areas and the issues that must be dealt with in formulating health policy and programs.

"Through the years, research and reporting about rural areas... have lagged behind similar work for urban areas."

Finance

State and federal reimbursement formulas differentiate between urban and rural areas, but often to the disadvantage of rural providers. For example, rural providers are reimbursed at a lower rate based on a wage equalization factor, which makes it difficult to attract qualified health care personnel. State and federal definitions of "rural" also differ. Additionally, rural providers frequently are not able to take advantage of economies of scale because of the small size of their institutions. Recommendations based on these findings are to:

- Sensitize and adopt reimbursement methodologies to meet actual rural needs, conditions, and operational shortcomings.
- Improve access to capital dollars.
- Provide dollars for grant demonstration projects, i.e., money to encourage joint ventures and other innovative programs.
- Enhance the dollar amount available for "medically indigent people."

Personnel

Qualified personnel and health care professionals are in short supply in rural areas, due in part, to the historically lower salaries and (previously-mentioned) lower reimbursement rates. Additionally, rural

health care professionals frequently must be recruited nationally and regionally, as well as locally; consequently, rural providers can incur the same labor costs as urban providers. Some common recommendations:

- Stimulate the recruitment and retention of health care workers (doctors, nurses, etc.), specialists, and support staff who are in short supply, and staff who are versatile in meeting particular needs of rural areas, e.g., a nurse practitioner who can also serve as a health educator.

- Provide more administrative backup to "one-man" operations wherein one person in a small rural health care organization must assume several responsibilities, i.e., administrator, raise funds, pursue grants, and the like.

- Improve dollar support necessary to attract and retain health care personnel in rural areas.

- Provide dollar incentives in terms of taxes, insurance, and education for professional personnel, informal care givers, and volunteers.

"People and institutions in rural environments feel disenfranchised in the key policy-making forums and units."

Comment

Once put into effect, many of these recommendations will benefit more than one aspect of rural health care. For example, the advocacy group mentioned under "State Policy, Regulations, and Codes" will undoubtedly be concerned with recommendations made in all categories and actually take the actions recommended in more than one category. Likewise, the information-sharing network under "Communication and Representation" could publicize successful rural programs, a task listed under the rubric of "Research." One group suggested, as a supplement to existing programs, appropriating a pool of funds on a regional basis for practitioners who commit to locate in underserved health manpower shortage areas — a suggestion that would address financial and personnel issues at the same time.

"...the health care industry is in a state of rapid transition..."

People and institutions in rural environments feel disenfranchised in the key policy-making forums and units. More equitable representation of rural interests through adding rural representatives to existing health policy units would enhance communication of unique rural needs and conditions between rural and urban policymakers and providers. These and many more ideas and recommendations are detailed in the summaries of the individual workshops.

The four symposium groups recognized the need for new initiatives to assure not only that current access to first-rate health care in rural areas is improved, but that access to the full continuum of health care services is enhanced as well.

Finally, it must be said again that the health care industry is in a state of rapid transition and turmoil with the outcome uncertain for everyone. Rural health care is potentially at great risk for profound systemwide change, and the consequences may be severe, even uncompromising, for health care providers and persons or families needing assistance in rural New York. In the future, rural hospitals and other rural providers must not be obstructed in developing new and innovative arrangements to successfully adapt to changes.

As Senator Cook noted in the foreword, a bill has already been introduced in the legislature as a direct result of work done at the symposium. The distribution of this report is expected to generate further positive action, at least in terms of solidifying the information-sharing network that is now being established among providers of rural health care. Meanwhile, the Commission on Rural Resources will continue to be a catalyst for ensuring that the critical issues outlined in this report are adequately addressed.

The Making of the Symposium

Since the 1940s, rural New York has been undergoing a series of gradual socio-economic changes. Prominent features of these changes that affect the health care system include the erosion of traditional economic bases of support, particularly in agriculture, but also in manufacturing industries. Additionally, we now find a higher proportion of elderly people in rural areas than in urban populations, and a higher proportion of poor people without adequate health insurance.

"...at the same time as we feel... pressure to cut costs in health care, we are more acutely conscious... of the need to improve the quality of this care."

Today the health care system in rural New York is in the throes of comparatively sudden change. From a social model of providing services to all who need them, regardless of how geographically scattered the people may be, we are quickly moving to a model of providing health care services that is based primarily on economic considerations. The historical background and the consequences of this shift were convincingly portrayed in the paper prepared by Dr. William Streck; and a keen awareness of this shift was reflected in the other three conference papers as well as in the separate workshop discussions with participants.

Today we live in an era of financial belt-tightening. The federal deficit has escalated to an almost unimaginably high level, and the effects of this are beginning to touch our lives. "Cost containment," whether applied to defense spending, to education, or to health care, is a fact of life now, and will be a primary influence on how we govern ourselves for the foreseeable future.

Ironically, at the same time as we feel unremitting pressure to cut costs in health care, we are more acutely conscious than ever of the need to improve the quality of this care. "Excelsior," ever higher, always upward, is more than just a word on the New York State seal — it also describes the desire we have regarding the quality of life in rural New York. The desire to make things better is an ingrained part of the American spirit. It has always been an important influence in our national history, and it is not surprising to find it to be a driving force in addressing health care issues in the state's rural environs.

Clear evidence that this spirit is alive and well in rural New York was provided in Cooperstown on November 14-15, 1985.

Earlier, in February 1985, to promote awareness of needs in rural New York and alternative ways to deal with them, the Legislative Commission on Rural Resources sponsored a rural development symposium at which a committee on rural health care developed a wide-ranging report on the issues. Following that, a series of public hearings was held across the state in order to get additional grass-roots commentary from people.

At one of these forums, in Cooperstown, participants focused on the necessity for frank, in-depth analysis and discussion of rural health care needs with the state, and they urged the Commission to initiate a follow-up conference for this purpose. The very survival of key rural health care institutions and services was being seriously threatened, they said; adding that the current state health policy was monolithic and incapable of providing a suitable framework for rural health care revitalization and development. Concerned citizens and health care providers alike felt disenfranchised from their government at the state and federal levels where decisions on health care policy were being considered by policymakers who unknowingly were doing serious harm to rural health care services. Striking evidence of this fact was given in testimony received by the Commission at the hearing held in Cooperstown. It had been four decades since a previous comprehensive statewide

conference was held involving state and local interests and policymakers in incisive analysis and discussion of rural health care goals and strategies.

Following the Cooperstown hearing, the Commission formed a planning committee for a statewide conference on rural health care; four papers were commissioned. These four papers became the foundation for the Cooperstown workshop group discussions.

From all areas of rural New York, men and women from public and private life came to work together. Physicians and nurses; hospital administrators and board members; directors of nursing homes and home health care agencies; representatives of the state health and education departments; representatives of statewide and regional health advocacy groups; and representatives of major health insurance providers — all came to work with state legislators and key legislative aides. They met as a group of citizens with a common interest in making things better, as people concerned not only with their personal well being and the immediate present, but also with the quality of their neighbors' lives and the hope for a brighter future.

"...the parts of the health care system are becoming more than ever linked and inter-dependent."

This report of the conference proceedings marks the beginning of a journey. It is a rudimentary map of routes to be explored in creating a network of communication and services in a world of what in the past were seen as out-of-the-way rural islands; places that got by without much attention or help from government, and proceeded more or less on their own. These areas are now seen as environmental treasures that must be tended and nurtured, and it is becoming clear that the people who live here must be served by a system of health care that is very un-islandlike. In fact, the parts of the health care system are becoming more than ever linked and inter-dependent.

A sense of adventure invests this endeavor of defining what rural New York is at the moment and at the same time trying to make it into something different; that is, to make it an even better place to live and work. In discussing health care, we talk a lot about *minimum* standards, about *adequate* care, because a democratic society includes everyone, and we must have a base line to work from. What we are really working toward, as the conference discussions made clear, are *optimum* services, the *best combinations* of people, facilities, and systems that can be created.

* * *

While many conference participants were pushed into this fray by external social, institutional and economic forces, there was a vitality in their labors that reflected their personal moral concern and the fact that their response to those external forces was a grass-roots effort in the very best sense.

As an adjective, "grass-roots" has the connotation of rural as opposed to urban, but over the years the term has been equally applied to movements for change undertaken in cities as well as those begun in the countryside. This is fitting and stimulating to consider because the metaphoric roots of our society are, of course, the people — people who have the same fundamental aspirations and needs, whether they live in the New York City metropolitan area, in upstate urban areas like Buffalo-Niagara Falls, or in the rural Hudson Valley, the Catskills, the Adirondack North Country, in central New York near the Finger Lakes, along the southern tier, or approaching the Midwest in southwestern New York.

It is also exciting to consider the possibility that the grass-roots effort begun in Cooperstown may go through a parallel evolution elsewhere in the state. That is, we fully expect the innovative networks of communications and services that are developed in rural New York to serve as models of cooperation and local initiative for urban areas of the state as well.

The result will be new and more effective programs, with stronger links not only between one provider and another within rural areas, but also between rural and urban providers. In our state as well as in our nation we can no longer afford the disenfranchisement and expense caused by monolithic health care policies or the illusion of living on islands.

Conference Opening

Senator Charles D. Cook, Chairman, Legislative Commission on Rural Resources-opening remarks at dinner

Senator Charles D. Cook, Chairman of the Legislative Commission on Rural Resources, formally began the conference with a welcome address and introductions of his fellow legislators.

Darrell Jeffers, Director of the New York State Council on Health Care Financing, speaking on behalf of Senator Tarky Lombardi, Chairman of the Council and of the Senate Committee on Health Care, stated that "this conference could not have occurred at a more opportune time, as the health care system in New York State is beginning to undergo fundamental changes in the ways in which care is delivered — perhaps the most dramatic changes ever." He added: "These fundamental changes will undoubtedly have a particularly profound effect on rural health care. However, change should not be equated with something that is harmful. It should cause reflection and create an opportunity to be productive and creative."

Assemblyman James R. Tallon, Jr., Chairman of the State Assembly Committee on Health Care, then addressed the conference participants with a charge that had a rallying cry ring to it. "Remember that the people who live in rural New York are the reason why we are here," he said. "The people's benefit, that is our ultimate goal, and we should start with their concerns and not lose sight of them....The fiscal constraints that are forcing us to confront these issues do, in fact, have a positive aspect — they create an atmosphere which

Top:
Darrell Jeffers-rep
Senator Tarky
Lombardi,
Chairman
Senate Health
Committee-opening
remarks at dinner.

Right:
Assemblyman
James R. Tallon, Jr.
Chairman,
Assembly Health
Committee-opening
remarks at dinner.

motivates us to take risks in creating programs to resolve the problems....It is a time to be conservative in hewing to the line of providing adequate services, but it is also a time to be innovative and daring..."

After this keynote, summaries of the four discussion papers were delivered by their authors:

William F. Streck, M.D. — *"On Rural Hospitals and Access to Medical Care: Social Versus Economic Models"*
David F. Perry — *"On Issues In Rural Health Care Delivery"*
John J. Finn, Ph.D. — *"On Rural Health Care Financing"*
Euphemia Hall and Warren Marcus — *"On Developing A Workable State-Local, Public-Private Partnership System of Rural Health Services"*

Following the presentation of the white papers in the plenary session, the focus of the symposium shifted to the participants and their involvement in the prioritization of rural health care issues and the development of strategies to deal with the issues.

Delivery of the White Papers L. to R.: Assemblyman Anthony J. Casale, Senator L.S. Riford, Senator Charles D. Cook, Chairman, Legislative Commission on Rural Resources, Dr. Wm. F. Streck, Assemblyman James R. Tallon, Jr., Warren Marcus, Mickey Hall.

Senator Cook stressed the need to proceed in a strictly disciplined fashion toward each workshop group's final report. The first step the Senator outlined was for each workshop group to define the issues, and set priorities on items where constructive, effective action could be taken, with emphasis on inherent systemic problems. The second part of the group's charge was to separate out the roots of those difficulties, with emphasis on state policy. The third and last major task was to cite what the group proposed to change explicitly; including how the suggestion was to be implemented, who would do it, and the steps that would have to be taken. This last step was described by Senator Cook as being the real heart of each group's work, with perhaps two-thirds of its time devoted to this task.

"The idea was for each workshop group to... develop imaginative, workable responses."

The overall objective for each group was to develop recommendations as nearly as possible to an outline that could be translated directly into action, being careful in using words to ensure that what the group asked for would be fully understood and not misinterpreted. The need to develop complete proposals was stressed as opposed to a myriad of nebulous statements.

Finally, Senator Cook cautioned that it was not expected this one workshop would solve all rural health care problems; nor that all suggestions made would eventually be implemented. The idea was for each workshop group to articulate needs in the rural health care system and to develop imaginative, workable responses.

Then the four workshop groups convened, and worked until late in the evening to develop a consensus on what the most important rural health care issues were in the areas of "Access," "Delivery," "Financing," and "Partnerships."

With these topics fresh in mind, members of the groups joined together again the next morning and afternoon to round out their discussions and recommend specific actions for addressing the problems as they saw them.

At mid-afternoon on the second day, their work was presented in the following summary reports.

Rural Hospitals and Access to Medical Care: Social Versus Economic Models

Workshop Moderator: Assemblyman Anthony Casale

Facilitator/Recorder: David L. Boucher

Resource Persons: William F. Streck, M.D. and Ronald Rouse

Workshop Summary: Presented by Robert J. Kayser

Introductory Remarks:

The first charge of the workshop participants was to identify the key priority issues dealing with the subject of rural access to health care. Based on Dr. Streck's presentation and paper and the experiences of the individual workshop participants, five priority issues were identified as:

- Recognition of the costs of delivering health care in a rural setting.
- Implication of state hospital code and other regulatory requirements on rural health care delivery.
- Representation of rural health care interests at the policy-making levels of government.
- Fragmentation of transportation services limiting access to rural health care services.
- Creation of a blueprint for the development and integration of health and non-health care services within rural areas.

A summary statement and a recommended course of action for each of these issues were developed by the workshop participants and are outlined below.

"...rural health care providers must recruit both locally and nationally for... personnel..."

The Cost of Rural Health Care

Summary Statement of the Issue:
Both state and federal reimbursement formulas differentiate between urban and rural providers and pay rural providers a lower rate based on a wage equalization factor. These differences in reimbursement rates fail to recognize the fact that rural health care providers must recruit both locally and nationally for technical and other professional personnel and therefore incur the same labor costs as urban providers. In addition, rural providers are not able to take advantage of economies of scale because of the small size of most rural institutions. Conversely, most urban health care providers realize significant economies of scale and therefore lower unit costs because of higher patient volumes.

Recommended Action:
In order to properly recognize the cost of providing health care services in a rural setting, the following action should be taken:

- Develop through the Legislative Commission on Rural Resources a data base which identifies the true costs of providing health care services in a rural setting.

- Obtain changes in both state and federal regulations in order to eliminate wage and other cost differentials between rural and urban health care providers.

Workshop on Access
Assemblyman Anthony J. Casale, presiding

State Hospital Code and Other Regulatory Requirements

Summary Statement of the Issue:
A number of state hospital code and other regulatory requirements place an undue burden on rural health care providers and therefore inhibit rural providers from providing cost-effective services. For example, the state hospital code requires specific minimum staffing levels and restricts the cross utilization of personnel in obstetrical suites. These state code requirements have therefore increased the costs of providing health care in rural areas, and in many instances have resulted in closure of services, which has further limited access to health care for rural residents.

"...state code requirements have... increased the costs of providing health care in rural areas..."

Recommended Action:

Because of changes in health care delivery, the emergence of alternative health care services, and the problems associated with access to health care in rural areas, there is a need to review all state hospital code and regulatory requirements. The following action, therefore, is recommended:

"...there is a need to review all state hospital code and regulatory requirements."

- Request the Administrative Regulations Review Committee (ARRC) to solicit comments and review all applicable state hospital code requirements for possible revision.

- Incorporate new regulatory provisions and provide grant funding to permit the development of innovative solutions for providing health care services and utilizing health care resources in rural areas. For example, a provision to permit swing beds would recognize the problems of accessing long-term care services in rural areas and would further enhance the utilization of small rural institutions that experience significant fluctuation in occupancy.

- Provide incentives for rural institutions to develop networks/multi-institutional arrangements in order to enhance access to health care and reduce the costs of delivering health care in rural areas. For example, Part 86 could be modified to permit institutions to retain a portion of the savings that may be attributed to multi-institutional arrangements.

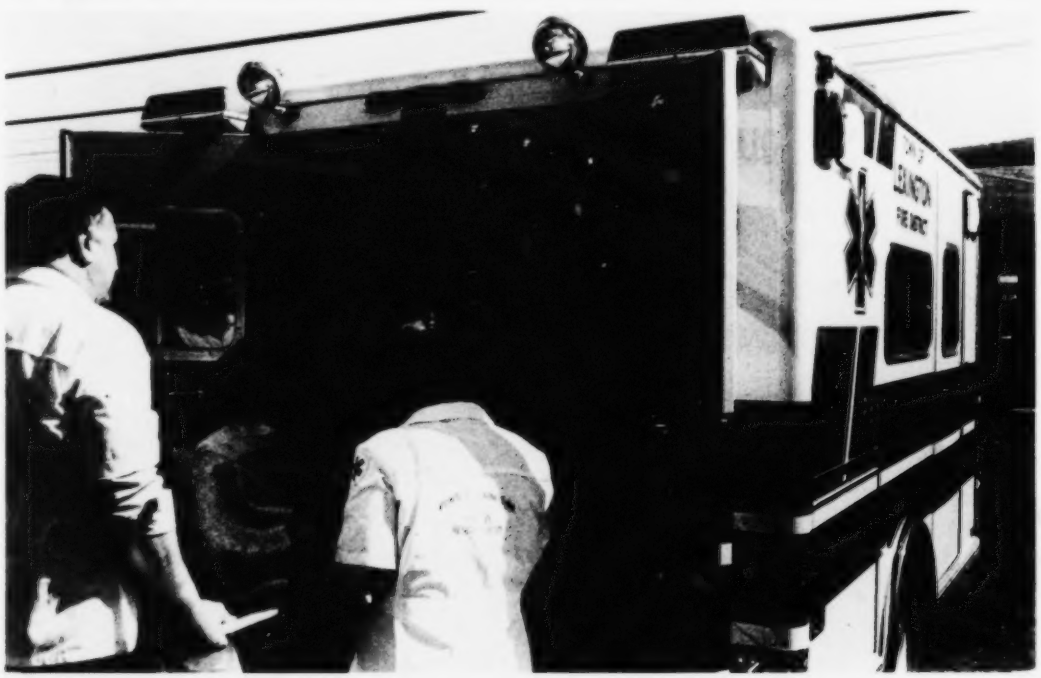
Rural Representation and Policy Making

"...rural residents...have not had adequate representation in policy-making levels of state government."

Summary Statement of the Issue:
Because the state has traditionally had a primary focus on large urban providers and population centers, the rural residents in New York State have not had adequate representation in policy-making levels of state government. Rural health care providers who are geographically dispersed and small in organizational size by comparison to urban institutions are also affected by this dilemma.

Recommended Action:
In order to enhance rural representation in the policy-making levels of government, the following action is recommended:

- Review the membership composition on the State Hospital Review and Planning Council with consideration to creating greater representation for rural interests.
- Restructure the Rural Hospital Advisory Committee as a statutory body and as a recommending body to the New York State Department of Health. This advisory committee could provide input on the impact of state codes and regulations relating to the delivery of health care in rural areas.



The all-volunteer Rescue Squad is the primary emergency vehicle to transport patients to the hospital. Timing is crucial in the rural environs, and squads in neighboring towns work together to provide ongoing 24-hour service to the community.

Patient Transportation

Summary Statement of the Issue:
The lack of adequate transportation is a major barrier in obtaining health services for many residents of rural areas. This situation is particularly acute for the elderly residents and for the working poor. Unlike the major urban centers in the state where there are major transportation systems in place, mass transit is either unavailable or restricted to certain population groups.

Recommended Action:
In order to reduce the impact of transportation as a barrier to accessing health care in rural areas, the following action is recommended:

- Provide tax and other incentives for volunteers who transport rural residents to health care services.
- Consider legislative action to pay for liability costs on a statewide basis for not-for-profit organizations and volunteers.
- Expand the transportation system for patient transfers and general patient transport by modifying Section 18 of the State Transportation Code to increase the flexibility regarding geographic boundaries and the population groups who are eligible to utilize existing transportation services.

"The lack of adequate transportation is a major barrier in obtaining health services for many residents of rural areas."

Non-emergency transportation is virtually limited to the family or friend's car and is a major barrier in obtaining health services especially with patients needing oxygen (shown here) or medical equipment usually found only on an emergency medical vehicle

Blueprint for Rural Health Care Delivery

Summary Statement of the Issue:
The most important goal of rural health care is to assure accessibility to affordable quality health care. There is a need to develop a blueprint or action plan to ensure that this goal is achieved. A rural blueprint would outline the needs and recommended actions regarding related issues of capital, primary medical care, emergency medical services, and education that further impact on access to health care services in rural areas. Moreover, it may be more useful to seek a full array of providers than to expect the acute system to do it all. Public support of each rural hospital should not be based on the simple fact that it is there, but whether it is the one that can best provide high quality, affordable services in a given area.

Recommended Action:
In order to develop a blueprint for rural health care delivery, the following action is recommended:

- Establish through legislative action a rural policy research center for health care delivery in New York State. This proposed policy research center could assess the impact of major legislative and regulatory programs on rural health care. In addition, innovative health care programs that are responsive to rural needs could be tested. For example, the cost effectiveness of training informal care givers and providing tax incentives for their provision of support services could be evaluated.
- Provide state tax exempt capital financing for rural health care providers.
- Evaluate the implications of the preliminary report of the New York State Commission on Graduate Medical Education on primary care in rural areas. The enhancement of medical educational programs in rural settings assumes more importance in the present health care era.

Workshop Summaries

Delivery of Rural Health Care Services

Workshop Moderator: Senator L.S. Riford, Jr.

Facilitator/Recorder: Robert M. Latham

Resource Persons: Seth Gordon and Gladys Olmsted

Workshop Summary: Presented by Donna Bird

Introductory Remarks:

We viewed the rural health care delivery system in the context of fundamental changes affecting the way in which health care is financed and delivered. Among the changes noted: movement from a cost-based to price-based reimbursement methodology, such as the use of DRGs for hospitals and RUGs for nursing homes; and the shrinkage of acute care capacity. Also noted was the expansion of such nontraditional services and health care delivery modes as health maintenance organizations, ambulatory surgery centers, home health care, and other forms of alternative service arrangements. Socioeconomic and demographic changes were also considered, particularly in the context of an increasingly larger rural elderly population and loss of economic bases.

"Small and rural hospitals face special problems..."

In attempting to address the significant impact of these changes, discussion was broadened from rural hospitals in particular, to the entire spectrum of rural health care delivery. We felt it important to take account of other providers (public health nursing, primary care clinics, and private practitioners of various sorts) while recognizing the major leadership role rural hospitals must continue to play in the coordination and delivery of rural health care services.

The following issues were identified as germane to the discussion:

- Small and rural hospitals face special problems, including the economically depressed state of many rural communities and older-than-average populations resulting in a disproportionately high percentage of Medicare patients.
- Access to capital financing will remain a primary issue for the foreseeable future.
- Chronic shortages and geographic maldistribution of skilled health care personnel continue to place contraints on rural health care delivery throughout New York State.
- Rural health care delivery is often lacking in sophisticated technology found in the urban medical care markets.
- Many small rural hospitals will have difficulty making cost cuts without reducing services; more rural hospitals may have to close or substantially scale back their range of services in the near future.
- The method by which HCFA differentiates between urban and rural hospitals differs from those methods employed by New York State, resulting in certain inequities.

Workshop on Delivery Senator L.S. Riford, presiding.

- There is regulatory sensitivity on the state level toward the rural health care delivery system; however, major problems persist.

Modified and condensed, three priority issues emerged as the most important to be addressed. Recommended actions were identified for each as follows:

Issue 1: There is a chronic shortage and geographic maldistribution of health care personnel, including home health aides as well as skilled medical personnel.

Main Principles:

- The survival of the state's rural health care delivery infrastructure depends on how well it is able to adapt to meet changing needs of patients and changes in the health care environment.

- Those rural hospitals that are successful work to develop community support, diversify into nontraditional areas to generate new revenue sources, affiliate or develop shared programs, and expand into new service areas, e.g., out-patient care, substance abuse treatment, long term care, and home care.

- In direct and indirect terms, a rural community's viability is correlated to its hospital.

Benefits of Proposed Changes:

- Increased geographic availability, accessibility, acceptability, quality, continuity, and appropriateness of health care services.

- Facilitation of efficient, cost-effective health care delivery.

- Reduced fragmentation of health care services.

- Preservation and enhancement of the rural economic base.

Recommended Actions:

- Provide tax and other financial incentives to encourage health care personnel to establish practices in rural areas. Educational tax credits, combined with other federal/state tax credits, should be established for rural health care practitioners where manpower shortages, identified by the federal and state agencies having jurisdiction, exist. Additionally, existing programs, such as federal/state administered loan-forgiveness programs, should be expanded to include health professions where manpower shortages exist as well (again defined by the federal/state agency having jurisdiction).

"...shortages and...maldistribution of health care personnel ...place constraints on rural health care delivery."

Lead Agency
NYS Department of Taxation and Finance
NYS Department of Health, Office of Health Systems Management
NYS Legislature

Home health care is available to rural patients — nurses and social workers (shown here) are available through many of the Home Health Care Agencies in New York State.

- Appropriate a pool of funds on a regional basis, to be allocated to practitioners who commit to locate in underserved health manpower shortage areas. Suggested uses of funds include start-up costs, such as full or partial payment of medical malpractice premiums, office overhead and/or related operating costs.
  Lead Agency
  NYS Legislature could initiate the appropriations and methodology through legislation.

- Develop demonstration programs that would encourage hospitals to become more actively involved in networking and shared services. Funds could be administered through Requests for Proposals (RFPs) incorporating defined criteria utilized by successful delivery models. Criteria should incorporate those elements of the NYS rural school network appropriate to a rural health care delivery model.
  Lead Agency
  NYS Department of Health, Office of Health Systems Management
  NYS Legislature

- Compile and disseminate information pertaining to innovative and successful rural health care delivery models addressing issues of resource constraints.
  Lead Agency
  NYS Department of Health, Office of Health Systems Management

- Increase third party reimbursement for physicians and other licensed primary care providers who are engaged in private practice in underserved health manpower shortage areas.
  Lead Agency
  NYS Legislature
  NYS Insurance Department
  NYS Department of Health, Office of Health Systems Management

- Sensitize the medical community at large to rural health care needs particularly regarding the use of other licensed health care practitioners (e.g. nurse practitioner, physician extender).
  Lead Agency
  NYS Department of Education

- Decentralize educational opportunities geographically, especially for non-physician practitioners.
  Lead Agency
  NYS Department of Education

Issue 2: Cost containment efforts are affecting the ability of rural health care providers to continue their work.

Main Principles

- The dynamics of the health care delivery system are rapidly changing and will predictably continue to change.

"Missions must be rethought and strategic planning and interinstitutional communications intensified..."

- The survival of the state's rural health care delivery infrastructure depends on how well it is able to adapt to meet changing needs of patients and the changes in the health care environment.

- Missions must be rethought and strategic planning and interinstitutional communications intensified so that a retooling of services, blueprinted to new specifications consistent with new and emerging changes, is accomplished.

- In direct and indirect terms, a rural community's economic viability is correlated to its hospital.

Benefits of Proposed Changes

- Increased geographic availability, accessibility, continuity, and quality of health care services.

- Reduced incidence of morbidity and mortality for rural populace.

- Promotion of equitable and appropriate geographic distribution of health care services.

- Increased opportunity for development and continuation of programs structured around health education, maintenance, and prevention.

"Financial incentives should be created and regulatory disincentives removed..."

- Encouragement of cost-effective and effective use of health care resources and services.

- Advancement of public policy sensitive to and reflective of the unique conditions and difficulties surrounding rural health care delivery.

Recommended Actions:

- Financial incentives should be created and regulatory disincentives removed to encourage development and growth of organized, integrated, and comprehensive networks of care between hospitals and other community providers. Included are mechanisms designed to encourage the establishment of consortia and joint ventures where feasible:

(1) Development of demonstration programs to serve as initial incentives for a period of one (1) year through regional allocation of start up money and seed money funds. RFP criteria to include those elements of the NYS rural school network appropriate to a rural health care delivery model.

(2) Provider consortia to be directly involved in the review, monitoring, and evaluation of select demonstration programs on intra and inter-regional basis.

(3) Upon expiration of demonstration program, preparation of report to be submitted to the Legislative Commission on Rural Resources. Report to include specific recommendations developed, in part, by regional consortia, county and local governments, HSAs, and the NYS Department of Health. Quantitative evaluation techniques should be employed incorporating methods of cost-benefit analysis. Social and other public policy considerations to be factored into final report.

Lead Agency
Legislative Commission
on Rural Resources
NYS Department of Health, Office of
Health Systems Management

- Legislative review of regulatory proposals should incorporate an awareness of both cost and system impact factors concerning rural health care delivery. Primary consideration should include, at a minimum, social and monetary cost in relation to the benefits derived.

Lead Agency
Legislative Commission
on Rural Resources
Legislative Agency for Regulatory Review

- Compile and disseminate information pertaining to innovative and successful rural health care delivery models addressing issues of cost and resource constraints.
  Lead Agency
  NYS Department of Health, Office of Health Systems Management

- Establish statutorily-defined minimum levels of health care services necessary to preserve and protect the health and welfare of residents residing in rural areas. Included could be the creation of funding mechanisms and financial incentives to maintain minimum service levels in those communities where it would be impossible to maintain those levels without such assistance and/or financial intervention. For instance, rural communities, for purposes of determining minimum health care service levels, could be defined as those communities located in a county with a population density of not greater than 150 persons per square mile. (Similarly, geographic parameters could be limited to rural counties as defined by having a population density not greater than that specified above.)
  Lead Agency
  Legislative Commission on Rural Resources

- Creation of discrete pool of funds to be allocated among programs and providers emphasizing health education, wellness, and chronic care maintenance in rural areas.
  Lead Agency
  NYS Department of Health, Office of Health Systems Management

The Victoria Graham Associates is the only private health clinic in NYS. It provides diagnosis and treatment of a range of communications disorders to patients in a four county area.

"In direct and indirect terms, a rural community's viability is correlated to its hospital."

Issue 3: Rural health care delivery is adversely affected by a variety of regulatory inequities.

Main Principles

- The dynamics of the health care delivery system are rapidly changing and will predictably continue to change.
- The survival of the state's rural health care delivery infrastructure depends on how well it is able to adapt to meet changing needs of patients and the changes in the health care environment.
- In direct and indirect terms, a rural community's viability is correlated to its hospital.

Benefits of Proposed Changes

- Strengthened and improved ability of rural health care delivery infrastructure to respond and adapt to present and future health care dynamics.
- Promotion of regulatory sensitivity to the unique problems and circumstances, surrounding rural environments in general, and rural health care delivery in particular.
- Decreased potential for reduction, erosion, and/or elimination of needed health care services.
- Potential to reduce need for subsidization of necessary rural health care programs and services.
- Increased potential for improving financial base of rural health care delivery system, preserving existing programs and services, and stimulating growth.
- Elimination of inconsistent, incongruent, and obsolete code language.

Recommended Actions:

- The NYS Department of Health's Rural Hospital Advisory Committee should be consulted as to existing problems and difficulties confronting rural health care delivery. Identified problems should be incorporated into a master inventory inclusive of other community health care providers. Comprehensive survey instruments could be devised by provider-specific category with results catalogued by respective issues. An in-depth evaluation per each problem/category to follow with specific recommendations developed per each. A rural health care delivery ad hoc task force consisting of provider, legislative, and executive branch representation should be formed for this purpose.
  Lead Agency
  NYS Department of Health, Office of Health Systems Management
  NYS Department of Social Services
  NYS Office of Mental Health
  Legislative Commission on Rural Resources
- Encourage regulatory coordination between state agencies (e.g., OHSM, OMH, DSS) and between state agencies and external accrediting/licensing bodies (e.g., JCAH and NYS Department of Education).
  Lead Agency
  Legislative Commission on Rural Resources
- Standardization of terms and definitions (where feasible and practicable) relative to rural health care delivery.
  Lead Agency
  Legislative Commission on Rural Resources

Workshop Summaries

Rural Health Care Financing

Workshop Moderators: Assemblyman James R. Tallon, Jr. and Ms. Jo-Ann A. Costantino

Facilitator/Recorder: Mr. Darrell Jeffers

Resource Person: John J. Finn, Ph.D.

Workshop Summary: Presented by Mr. Richard O. Langham

Introductory Remarks:

Every resident in New York State, regardless of whether he or she resides in a rural or urban area, is entitled to the same minimum standard of health care. To ensure that this level of care is made available, health care financing and service planning discussions must recognize the different characteristics of providers and consumers within the state.

"The current health care payment program does not recognize, in most incidents, the variations in how health care services must be delivered in the rural community..."

The fact is that at this time NYS has a monolithic health care policy with regulations that apply, with some very minor exceptions, to all providers — regardless of the size, type, or location of the facility. Furthermore, recognition of the unique nature of rural communities is on an exception basis. Adverse consequences of this situation include cash flow impairment and failure to directly and adequately address the variation in needs and resources to meet these needs.

The current health care payment program does not recognize, in most incidents, the variations in how health care services must be delivered in the rural community —i.e., variations between one rural provider and another as well as differences between rural and urban providers. Rural providers must cope with differences caused by the low population density of rural areas. These include: more fluctuating, less specialized or concentrated use of the provider and its services; limitations on the availability of skilled human resources; transportation problems of both the patient and the provider; lack of alternative providers; and the community service burden of being a sole community provider. These combine to generate higher unit costs for all providers and make it difficult to provide services in an efficient and effective manner. In addition, these conditions frequently can produce a higher length of stay for patients in rural hospitals.

With this in mind, the following specific issues are identified as being among the most critical; and the recommended actions are seen as steps toward creating a state health care policy that treats rural NY more directly.

Issue 1: Factors unique to rural areas sometimes make the cost per unit of health care service higher in rural areas than in urban centers. These factors include:

The Jewett Medical Center re-opened in April, 1986 as a satellite of the Stamford Comm. Hospital to provide on-going office services with 3 M.D.s or physician's assistants. Shown here is the diabetic blood test. Smaller facilities such as this one are providing health care on a continual basis, where in the past, one doctor was available.

"Providers in rural environs . . . experience a greater variety of demands on their services . . ."

- **Utilization** — Providers in rural environs tend to be smaller and experience a greater variety of demands on their services; additionally, small size and low population density tend to discourage specialization of services. The size factor affects costs, since there is generally an absence of "economies of scale." Such unique rural conditions frequently lead to significant increases in unit costs of purchasing and delivery of services for individuals, families, and providers.

- **Transportation** — Transportation services are less available in rural areas than in urban ones. Distances and geographic barriers are also greater in rural areas. Inclement weather can be more disruptive in rural areas as well. This produces greater difficulty and cost in getting the patient and provider of service together. Where the service is provided is immaterial to this conclusion. Rural health services are impacted by the greater cost and lesser availability of transportation services. However, this difference is not fully recognized by existing payment mechanisms.

- **Human Resource Limitations** — Qualified personnel and health care professionals especially are in short supply in rural areas. This is due, in part, to the historically lower salaries in rural areas, and the present reimbursement system now in place maintains this salary disparity. In fact, the disparity between metropolitan and rural income is widening. Salaries are important incentives to attract high quality personnel, both medical and administrative; as are other factors such as amenities, availability of professional support and health care facilities. Without adequate salaries and basic support systems and facilities the shortage of skilled personnel will be aggravated in rural areas.

- **Alternative Providers** — Many rural communities have only one provider. This means that the single provider must assume a significant responsibility, frequently maintaining necessary, but

"The need... is to promote coordination, continuity, and linkages..."

uneconomical services. This lack of alternatives is both a blessing and a curse. It is a blessing because it husbands the scarce health care dollars and avoids fragmentation of the health care delivery system where more providers would be scrambling for a small and only slowly growing number of dollars. It is a curse because many of government's rules and policies are based upon assumptions concerning the availability of alternatives. Examples include standards for admission, discharge, and length of stay for hospital inpatient care. Such standards are improper if appropriate support and delivery systems for non-inpatient care are unavailable.

- In those rural communities that have available such alternative care providers as health department clinics, family-planning clinics, primary care clinics, or home health services, the individual provider in these facilities frequently concentrates on one service or client group. The need in such communities is to promote coordination, continuity, and linkages in services among providers.

"The financial appeals process is now used to give greater flexibility in the reimbursement system but is unduly time-consuming and expensive."

Recommended Actions:

1. Change the definition of "rural" as applied in health care to be more sensitive to specific issues that affect rural institutions, e.g., the lower volume of services, the changeability and less specialized nature of services provided, and higher transportation costs.

2. Promote joint ventures between providers that offer different specialized health care services and consolidation among those that promote similar services in order to achieve the "critical mass" of services necessary to make payment dollars flow, and to increase continuity and coordination of care among providers.

3. Examine closely the federal swing bed program to determine if this system would be beneficial as a partial solution to rural hospital issues.

Issue 2: The financial appeals process is now used to give greater flexibility in the reimbursement system but is unduly time-consuming and expensive. Delays in the processing of appeals submitted affect substantially all health care providers but especially those smaller, more remote agencies in rural areas. The dollar amount being appealed by a rural agency is typically a fraction of the amount being contested by a large institution, but to the small rural institution such amounts represent a significant portion of its operating budget and consume inordinate amounts of scarce staff time.

As the appeals process currently operates, it discriminates against the rural provider because the rural provider cannot individually afford to lobby intensely in Albany or with federal agencies — which larger institutions with more staff resources are better able to do. Because the lengthy appeals process typically works on the principle of "greasing the squeaky wheel" first, the rural community provider's case is too often put on the bottom of the pile of pending cases. Additionally, larger appeals (usually originating in larger institutions found in metropolitan areas) tend to be viewed as being more "critical" by the reimbursement agencies and therefore receive higher priority treatment.

Recommended Actions:

1. Establish a follow-through monitoring of the appeals process, particularly to ensure that mandated time frames are met.

2. Establish a government watch dog or oversight agency, to protect the interests of rural health care providers.

3. Ensure that rural health financing issues are directly recognized and incorporated in reimbursed regulations, avoiding the current "exceptions" treatment.

Issue 3: Rural health care providers are frequently hampered in obtaining necessary financing, especially for such capital goods as equipment, new systems, and facilities. Current government policy, programs and regulations that pertain to the acquisition of capital goods do not adequately recognize the unique conditions and needs of rural health care.

"Rural health care providers are... hampered in obtaining... financing,... equipment, new systems, and facilities."

Recommended Actions:

1. Support legislation that will allow the Medical Care Facilities Finance Agency to sell pooled funding vehicles — or legislation that will allow rural banks to lend money to groups of providers. At this time, only bonds for single institutions have been allowed. Technical assistance should be made available to small institutions as part of this bonding program, to assist them with the paperwork.

2. Set up a revolving loan program to enable institutions to borrow money at low interest rates to experiment with new ventures. This money, as it is repaid, would be recycled to other institutions for similar projects.

3. Eliminate the certification of need process, which may take from six months to three years, for new capital (non-care) programs under $2 million.

"Hospitals... in rural areas... fill many... roles,

Issue 4: There is a need to reexamine, and possibly augment funding of rural health services, especially those that are the only source of care in a locality. Hospitals are frequently used in rural areas as vehicles to fill many nontraditional roles, particularly in the areas of emergency service, social services, and mental health. Funding and delivery of these services are not always provided in the most effective manner. Additionally, as more alternative providers of services are created, fragmentation of scarce rural health dollars may occur, to the probable detriment of all. Such finance issues need to be addressed comprehensively to include all health care needs and providers in the community.

Recommended Actions:

1. Increase the funding for all providers to subsidize the care of those who are "medically indigent," defined as those who neither qualify for Medicaid nor have private health insurance to pay for their care.

2. Reexamine funding levels for rural county health departments to encourage participation in the delivery of health and mental health services and increased responsiveness to community health needs.

3. Establish comparable grouping for diagnostic and treatment centers for the purpose of Medicaid rate setting. (Presently, many rural centers are grouped with urban clinics which are not comparable but are grouped together because they are "upstate" vs. NYC.)

Workshop Summaries

Developing a Partnership System of Rural Health Services

Workshop Moderator: Senator Charles D. Cook

Facilitator/Recorder: Dr. Leonard Cutler

Resource Persons: Ms. Euphemia Hall, Mr. Warren Marcus, Ms. Doris Warrick

Workshop Summary: Presented by Dr. Leonard Cutler

Introductory Remarks:

Many of the issues raised in this workshop touched on the same topics as those dealt with by the other workshops, and discussions reinforced the points already articulated by members of the first three groups. Among these topics were:

- Retention, recruitment, and training of physicians and other health care professionals. Specifically, the structuring of medical education and other health professional education programs so they are properly geared to prepare practitioners for service in rural areas.
- More capital expenditures for plant and equipment replacement, e.g., outdated buildings built in the 1960s with Hill-Burton funds which are no longer available; and providing capital to allow rural hospitals to expand ambulatory care.
- Funding mechanisms to promote federal-state-community startup projects.
- Reimbursement which takes into account special needs for rural populations particularly elderly/isolated.
- The need to enhance the role of the HSA with respect to grant development projects.

Two priority issues were identified, however, and specific actions were proposed to address these problems. In these areas, as well as those mentioned above, it should be noted that our recommendations strongly support the findings of the other groups.

Issue 1: The need to develop legislative incentives — to promote networking, and to establish eligibility for the waiver of state regulations for rural health care providers.

Main Principles

- We need to establish a new network of state-local, public-private, and rural-urban partnership in the continuum of health care.
- The rural hospital is a focal point and vital component of this health care continuum.

Workshop on New Partnerships
Senator Charles D. Cook, presiding.

Benefits

- Reduced fragmentation of health care services.
- Greater sharing of information and resources among rural providers in order to promote continuity in patient care.
- The generation of an atmosphere for proper planning to address change in health care delivery systems.

Tools/Elements Utilized

- Grant demonstration projects utilizing incentives to promote cooperation in such areas as acute, primary, home health, hospice, and respite care.
- Use of a lead agency or agencies on behalf of a provider or group of providers.
- Upfront funding for in-depth development of projects in the $10,000 to $50,000 range.
- As needed, for the duration of the project, a continuation of waivers required to successfully implement and test the program.

As a prerequisite to be eligible for grant funds, the lead agency or agencies must have some communication with all providers, and be aware of the level of health care being provided within the same service area.

The review process for demonstration grant proposals will begin with local HSA review and recommendation to the Rural Hospital Advisory Committee within the State Department of Health, which will in turn review proposals and make its recommendations for grant awards to the Commissioner of Health.

Lead Agency for Initiating Action

The legislature may serve as a catalyst in the grant award process by proposing legislation stipulating that the Rural Hospital Advisory Committee perform a review function, and that the entire local and state reviews be concluded within six months.

Issue 2: The need to create an independent state health commission specifically charged to serve as an advocate for rural hospitals and other health care providers.

"A comprehensive health policy appropriate to rural New York State is necessary."

Main Principles

- A comprehensive health policy appropriate to rural New York State is necessary.
- Health care providers must interact vitally with other principal components of rural life.
- All health care providers should be subject to the same state regulatory process, including certificate of need.

Benefits

- State policy geared to changing rural circumstances will become more sensitive to rural conditions.
- The state health care system will more appropriately address the needs of the state's diverse rural areas.

The Stamford Community Hospital emergency room handles all critical patients within an hour's ride, and is typical of the smaller hospitals available in the rural community. When specialists are required, the patient is stabilized and then transferred to a larger facility.

- Unique rural factors that affect the cost of health services will be reflected in the adjustment of reimbursement rates and regulations.

Tools/Elements Utilized

- Creation of the New York State Rural Health Commission, comprising seven members, three appointed by the Governor with the advice and consent of the NYS Senate, and one to be appointed by each of the following: the Senate President Pro Tempore; the Assembly Speaker; the Senate Minority Leader; and the Assembly Minority Leader.

The Commission would have the following powers and duties:

1. To research, study, and develop a rural health care policy for the State of New York.
2. To consider, comment on, and propose to the legislature and to the executive branch, legislation, rules, and regulations that will have an impact upon the rural health care delivery system.
3. To review and comment upon pending legislation, rules, and regulations (before appropriate state agencies) that affect the rural health care system.
4. To examine specific rural factors that should be considered in reimbursement for all sectors of health care.
5. Upon request by rural appellants, and after a favorable case review, to serve as an advocate with respect to rates, reimbursements, and regulations that apply to the rural health care provider.
6. To ask for and receive in writing within thirty days of initiation, a response to pending requests before appropriate state agencies.

Lead Agency for Initiating Action
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Appendix 3 — White Paper Abstracts

The following is a summary of the white papers prepared for the Rural Health Symposium. Copies of the original papers may be obtained by contacting the Commission office.

Rural Hospitals and Access to Medical Care: Social Versus Economic Models

by William F. Streck, M.D.

Four general themes are discussed in Mr. Streck's paper: 1) the two dominant political actions that have influenced the development of rural health care since the 1940s — the Hill-Burton Act in 1946 and the Medicaid/Medicare Act in 1964; 2) the consequences of these two pieces of legislation and how they have become politically and financially unacceptable since the late 1970s and early 1980s; 3) the past and present problems of access to health care in rural areas; and 4) the consequences of current political approaches now being taken in solving health care problems in general in the U.S. For rural providers, such approaches have resulted in: smaller hospitals which are capital poor, technologically behind, and economically threatened by the new federal reimbursement strategies; more physicians — who are not, unfortunately, choosing to work in rural areas; and, hardships for the poor and elderly via the decreased federal and state expenditures for health care.

Mr. Streck concludes with six recommendations which would enhance New York's rural health care system:

- Rural health care must be recognized as a distinct part of a complex system.
- Centralization of resources must be viewed as distinct from urbanization of resources.
- Capital support of rural hospitals must be provided.
- Transportation systems are an essential part of the delivery of health care in rural areas and should be seen as so.
- Educational programs in rural settings must take a more integral role in insuring maintenance of services, access to specialty care, and developing programs tailored for rural areas.
- New models for providing health care in rural areas must be developed.

Issues in Rural Health Care Delivery

by David F. Perry

Mr. Perry's white paper outlines the many changes currently occurring in health care delivery in New York State and just how small and rural hospitals fare (and may fare in the future) in relation to these changes. He then delves into the areas of capital, manpower, networking and integrated system design, and regulations, again discussed in relation to health care in general throughout New York State and rural health care in particular.

Issues in Rural Health Care Delivery contains detailed information in the "Manpower" section on chronic shortages and geographic maldistribution of skilled health care personnel — including a county-by-county map showing the number of physicians per 1000 population. The "Manpower" section concludes with a

list and brief description of major programs and initiatives now in progress to help alleviate shortages.

The "Networking and Integrated System Design" section urges a stepped-up effort toward joint networking and creating alliances within internal and external rural health care structures. The "Regulations" section, meanwhile, stresses a wish for the avoidance of imposing arbitrary or unnecessary standards on rural health care delivery since, as usually occurs, regulations are routinely written to address urban problems yet end up being applied statewide. These regulations frequently become equally binding upon rural facilities. Thus, the author would like to see regulatory sensitivity as well as regulatory flexibility.

Developing a Workable State-Local, Public-Private Partnership System of Rural Health Services

by Euphemia Hall and Warren Marcus

The authors present a five-part paper that is comprehensive in both presenting an overview of rural health care and in recommending goals, strategies, and action steps to achieve better state-local, public-private relationships in rural health care. The paper contains three specific public policy goals, 23 strategies that could help in achieving those goals, and a summary of what steps have been taken so far, including speculations on how these (and other) steps will or may affect the future of rural health care in the state.

The full spectrum of rural health care and related community services are mentioned in relation to developing these new partnerships: home health care, primary care, tertiary care, public health nursing, family planning, nutrition, and emergency medical services. Important points stressed in the paper are: 1) rural areas experience gaps in the above-mentioned services; 2) current regulations for rural health care are a piecemeal, bandaid approach in solving problems; and, 3) new state-local, public-private partnerships will require the involvement of *all* parties affecting rural health care.

Rural Health Care Financing

by John J. Finn

This white paper starts from the statement that New York State has yet to express a rural health care policy per se. Mr. Finn discusses the many implications of this lack of policy, particularly the financial burdens created for rural health care providers. He then discusses five areas of rural health care that must be recognized and dealt with in the reimbursement system the state will eventually come up with (three systems are now under consideration): low population density, distance, decreased availability of home care, lack of competition, and absence of commercially competitive ancillary services. Also mentioned are problems of capital financing the cost implications of PPS and DRG systems for rural health care.

"Rural Health Care Financing" concludes noting that beginning in 1987 there will be a new system of payment for non-Medicare payers in New York State. Mr. Finn urges that whatever system is adopted, it must both recognize rural differences and be sensitive to those differences a la the five areas mentioned above. Examples are provided. Closing the paper, two strong observations are offered: rural providers must organize in a manner that will effectively represent their interests and there should be formations of linkages among rural health care providers. The author believes in the networking of laboratories, radiology departments, computer systems, and financial services.

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